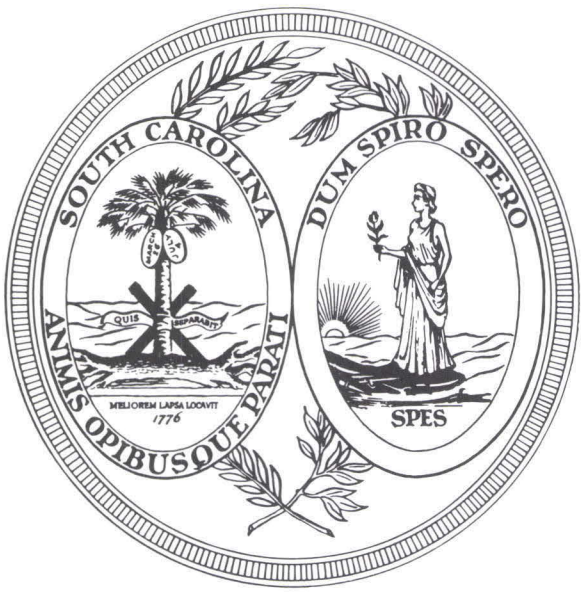
SOUTH CAROLINA
HEALTH AND HUMAN SERVICES
FINANCE COMMISSION



ANNUAL REPORT
1985-1986

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State of South Carolina

State Health And Human Services Finance Commission

P. O. Box 8206, Columbia, South Carolina 29202-8206

November, 1986

The Honorable Richard W. Riley
Governor, State of South Carolina
Post Office Box 11450
Columbia, South Carolina 29211

Dear Governor Riley:

The Second Annual Report of the Health and Human Services Finance Commission is hereby submitted. This report covers the fiscal year ending on June 30, 1986.

Sincerely,

William T. Putnam

William T. Putnam
Chairman

WTP/kam
Enclosure

1801 Main Street / Telephone Number (803) 758-3175

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HEALTH AND HUMAN SERVICES FINANCE COMMISSION
ACCOMPLISHMENTS FOR FY85-86

The Health and Human Services Finance Commission is the administrator and fiscal manager of South Carolina's Medicaid program, its Social Services Block Grant, and the Community Long Term Care statewide project. The Agency also has the statutory roles of serving as the State's chief health planning entity and as steward of the Medically Indigent Assistance Fund.

Medicaid is the grant-in-aid program by which the Federal Government and South Carolina share the cost of providing medical care to the low-income needy. Although almost one-quarter of a million South Carolinians had been certified as eligible to obtain Medicaid services by the end of FY85-86, Medicaid covers only one-half of the State's low-income population because eligibility is set at 50% of the Federal poverty standard. The $10,111 per capita income of South Carolina's 3.3 million citizens is ranked 46th in the United States and is four-fifths of the national average of $12,722.

The Federal Government paid 72.7% of the State's $409,456,217 Medicaid budget in FY85-86. South Carolina paid the remaining 27.3%. These funds were administered through the Health and Human Services Finance Commission, which contracted with other State Agencies and private providers to deliver health services to Medicaid clients. In a typical month, 63,000 persons recorded 169,000 physician consultations, 65,000 clients obtained 131,000 prescriptions; 15,300 patients received in-patient hospital treatment requiring 19,800 bed days; and another 19,300 clients were treated in out-patient settings in the course of 28,000 visits.

The number of clients eligible for Medicaid services rose from 219,970 to 233,577 in FY85-86, primarily due to legislation that broadened eligibility standards in Aid to Families with Dependent Children coverage.

A 12-day limit on in-patient hospital services was lifted and the Health and Human Services Finance Commission also increased its out-patient treatment fees. The Health and Human Services Finance Commission implemented a cost containment program that required mandatory out-patient surgery, pre-admission certification, second opinions on surgical procedures, enhanced utilization review, and incentives for out-patient treatment.

A refined utilization review system was phased in during FY85-86, with the goal of ensuring that all Medicaid clients receiving long term care in institutions are in the most appropriate treatment setting and could not receive quality care in alternative and less expensive placements.

The Community Long Term Care program, which provides home-based services, has been held up as a national model. During FY85-86, the number of participating clients more than doubled to 5,343 and the number of providers increased from 50 to 140. Over 14,000 persons

applying for Medicaid-sponsored long term care services were also screened for eligibility.

Another program undergoing a major increase in utilization is the Early and Periodic Screening and Diagnostic Treatment preventive health initiative. Its screening program for those Aid to Families with Dependent Children eligibles increased 49%. The Agency also implemented a High Risk Channeling project to screen all eligible pregnant women for risk factors and to ensure that those at high risk were treated by qualified practitioners in appropriate settings. During the year 2,900 clients were screened and 650 were revealed to be of high risk.

The $50,704,086 Social Services Block Grant program, the primary source of Federal funding for South Carolina's human service programs, is implemented through contracts between this Agency and approximately 100 contractors, including other State Agencies and community-based public and private providers. Among the 21 services provided 60,000 clients are such major activities as protective services for abused and neglected children and adults, in-home services to the homebound elderly, and child development services.

Management initiatives launched in FY85-86 include implementing the first of three phases of a quality assurance system for human services. This is the first attempt to systematically gauge the quality of services delivered and the impact of these services upon clients' lives. This is complimented by the implementation of the first methodical monitoring system evaluating the performance of service contractors and participating State Agencies.

Another development is the creation of a priority-setting system that would be triggered in the event of funding reductions such as the $1.6 million cut in Federal funding announced in March. The system sets priorities and establishes contingency plans to target diminished resources to clients with the most critical needs. It meant that the 4.3% Federal cut required only a 1% cut to be passed on to service providers.

The Medically Indigent Assistance Fund was established by 1985 Act No. 201 to aid citizens who cannot afford to pay for hospital care because of inadequate financial resources or catastrophic medical expenses. This Agency was designated to administer the program, which was implemented on January 1, 1986, with half-year funding of $7.5 million. This fund is formed by contributions from South Carolina's 46 county governments and its 82 general hospitals and may be spent only for in-patient hospital services.

The Agency paid 3,736 claims; the five major diagnoses involved the digestive system, pregnancy, circulatory system, respiratory system, and newborns/neonates. Of the 3,736 claims, 76% were for patients with incomes below poverty level; 21% were 19 or under, 69% were 20 - 59, an age group least likely to be sponsored by any government health program, and 10% were 60 years old or older. The $7.5 million fund was exhausted within five months.

The Health and Human Services Finance Commission utilized a

computerized diagnostic related group prospective payment system to pay Medically Indigent Assistance Fund bills, as well as in-patient hospital bills for Medicaid. South Carolina is one of 12 states with an indigent health care program and one of only three states which has created such a prospective payment system for its indigent health care program.

A well-developed diagnosis related group system can be a major cost containment measure without adversely affecting the clinical treatment of clients. The hybrid diagnosis related group system which the Commission has developed for its Medicaid program was carefully conceived to accomplish quality health care at a reasonable cost.

Under a cost reimbursement system there is no incentive to treat a patient in a cost-effective way. Under a diagnosis related group system, a predetermined payment is made for a given treatment. If the hospital can treat the patient for less, it makes a profit. If it treats the patient for more, it takes a loss. Not only does a diagnosis related group system give hospitals an incentive to be cost effective, but it also allows the State to participate in the price it is going to pay. By defining payment ahead of the transaction, the State is less vulnerable to "cost overruns."

The hybrid diagnosis related group system sets up a cost containment system in a regulatory environment that attempts to assure quality care. The Commission's hybrid diagnosis related group system is considerably more complex than the nationwide Medicare system enacted by the Federal Government. This is a deliberate effort to correct many of the inequities associated with that diagnosis related group system and to tailor the reimbursement to South Carolina's historical data. Furthermore, the Commission's much stiffer penalties for medically unnecessary discharges should assure quality care for our clients. South Carolina is one of only six states that has created a diagnosis related group system for its Medicaid program. It has also implemented an out-patient fee schedule which supports use of the most appropriate treatment site.

To guide the Agency's reaction to the revolutionary technological, financial, and philosophical changes now transforming American medicine, a strategic planning process has been implemented. This comprehensive effort to identify external factors that will affect the health and social services of South Carolinians is in addition to the continuing development of an interim long range Medicaid plan and the State's Human Services Plan.

A major step forward in the Agency's planning capabilities came with Federal approval of a proposal to transfer the Medicaid Management Information System from the Department of Social Services to the Health and Human Services Finance Commission. This computer system in the past has been effective as a claims payment and control system for the Medicaid program, handling 5 million claims annually with the claims being paid within 12 days of receipt on the average.

When the system is transferred October 1, 1986, work will begin to add enhancements that will augment the system's mission by permitting

management and planners to extract client profile information and other hard data.

The challenge is to maintain the sturdy claims payment system that the State has today, while evolving to a true management information system. The system must become even more flexible in handling budget and program changes and, especially, be more responsive to the changing information needs of Medicaid program managers and the State's policy-makers.

APPENDICES

APPENDIX A

HISTORY AND ORGANIZATION OF THE HEALTH AND HUMAN SERVICES FINANCE COMMISSION

The Health and Human Services Finance Commission was created at the 105th Session of the General Assembly by Act. No. 83, which was signed by Governor Richard W. Riley on June 7, 1983. This Act established an organizational and procedural framework for the planning, financing, and administration of programs provided for in the Act and established general policy for the allocation of resources.

Under the terms of this legislation, the Finance Commission was given the responsibility of administering the Social Services Block Grant program and Title XIX of the Social Security Act (Medicaid), with specific reference made to the inclusion of the Early Periodic Screening and Diagnosis Treatment program and the Community Long Term Care system.

A Transition Committee was appointed, as prescribed by law, and it began the development of work plans to identify functions and program components to be assigned to the Commission, enabling the new Commission to operate independently on July 1, 1984, as the law indicated. A summary of this Act is included in Appendix B.

BOARD OF COMMISSIONERS

The Health and Human Services Finance Commission is governed by a seven-member Commission. One member is elected from each congressional district of the State by the General Assembly. One must be appointed by the Governor from the State at large to serve as Chairman. The terms of the members are for four years and until their successors are elected and qualify, except that the initial members from the first, third, and fifth congressional districts must be elected for terms of two years each. Vacancies must be filled by the Governor for the remainder of an unexpired term. No person may be elected who has a conflict of interest and no member shall serve more than two consecutive terms. The Commissioners are: William T. Putnam, Chairman; Elise Davis-McFarland, Ph.D., District 1; Edward C. Roberts, District 2; T. Ree McCoy, Jr., District 3; Robert E. Robards, MD, District 4; Billy F. Pigg, District 5; and James L. Pasley, Jr., District 6.

The Commission has two committees that assist and advise it in its

functions. The law creating the Commission also created an Advisory Committee which addresses overall policy and reviews health and human services plans. The Medical Care Advisory Committee was established by Federal Law 42CFR431.12 to provide advice on all aspects of the Medicaid program. These committees' memberships represent a broad section of the State's population, including physicians, pharmacists, and other professionals in the health and human services delivery system, as well as Medicaid recipients.

OFFICE OF THE EXECUTIVE DIRECTOR

Dennis Caldwell, Executive Director, serves as the chief administrative officer of the Commission. His responsibilities are to execute policies, directives, and actions of the Commission. He is assisted by James D. Blair, Ph.D., Deputy Director of Operations; Deputy Director of Systems and Control (vacant); Benny F. Clark, Deputy Director of Programs; Ronald A. Thompson, Personnel Director; and Raymond G. Halford, Deputy Attorney General, who serves as Agency Counsel.

OFFICE OF PERSONNEL

The Commission's Personnel Office is responsible for the development, interpretation, and promulgation of personnel policies and procedures, monitoring all phases of employment relations including the Employee Performance Management System, disciplinary and grievance proceedings, benefits administration, position classification and compensation, and maintenance of personnel records.

OFFICE OF GENERAL COUNSEL

The Office of General Counsel represents the Agency in State and Federal courts and administrative hearings; and advises the Commission, the Executive Director, and staff on legal matters pertaining to the Commission, including the drafting and interpretation of statutes and regulations.

OFFICE OF AUDIT AND CONTROL

The Office of Audit and Control evaluates whether the Commission is carrying out its responsibilities according to statutory and regulatory requirements of the many health and human services programs, which are delivered by various service agencies and providers throughout the State.

The primary objective of Audit and Control is to assist management by providing information, analyses, and corrective action plans to the Executive Director.

OFFICE OF PROGRAMS

The Deputy Executive Director of Programs administers and coordinates the activities of the Bureau of Health Services, the Bureau of Human Services, and the Bureau of Long Term Care.

BUREAU OF HEALTH SERVICES

The Bureau of Health Services is responsible for the administration and coordination of certain Medicaid services and the Medically Indigent Assistance Fund. The Bureau is composed of the Divisions of Eligibility, Primary Care, Preventive Care, and Health Support Services.

Division of Eligibility

The Division of Eligibility develops the eligibility policies for the Medicaid coverage groups and the Medically Indigent Assistance Fund.

A. Medicaid Covered Groups

In South Carolina only those individuals who receive assistance through one of the following programs are eligible for Medicaid:

1. Aid to Families with Dependent Children

2. Supplemental Security Income

3. Medically Needy

4. Optional Supplement

5. Refugee Assistance

6. Eligibles Under the 1977 Pass-along Provision

7. Certain Children Under Age 21 with Special Living Arrangements

8. Medical Assistance Only Institutional Cases

9. Individuals Who Receive Home- and Community-based Services Under Waiver

10. Medical Assistance Only Eligibles in December, 1973, Who Are Protected by the "Grandfather" Clause

11. Certain Children Who Receive Title IV-E Adoption Assistance or Foster Care Maintenance Payments

12. Essential Spouses

B. Medically Indigent Assistance Fund

The Medically Indigent Assistance Fund pays for inpatient hospital services for persons who do not qualify for Medicaid assistance and who do not have means to pay for their care. The Medically Indigent Assistance Fund is funded by contributions from county governments and general hospitals.

Division of Primary Care

The Division is responsible for the program areas within Medicaid pertaining to the delivery and financing of primary health care services. The Division is organized into the Director's Office with responsibility for overall leadership and special projects and four Departments. Each Department is responsible for developing policies and procedures, conducting provider liaison activities and managing the various programs. All share the common goals of (a) ready access to high quality medical care for Medicaid clients, (b) obtaining the best buy for each dollar spent, (c) promoting broad-based participation and public support for Medicaid, and (d) effective program management.

Division of Health Services Support

The Division of Health Services Support administers support functions for the Primary Care and Preventive Care Divisions of the Bureau of Health Services. The Division of Health Services Support is composed of two Departments, the Department of Prepayment Medical Review and the Department of Reimbursement and Enrollment. Special consultative services are provided to the Department of Drugs and Durable Medical Equipment as well as liaison services with professional and advisory groups both within and external to the Commission.

Division of Preventive Care

The Division of Preventive Care is charged with planning, budgeting, administering, and managing the following Medicaid programs:

1. Early and Periodic Screening Diagnosis and Treatment
2. Dental
3. Vision Care
4. Speech and Hearing
5. Transportation
6. Early Periodic Screening Diagnosis and Treatment/Outreach

The Division is organized into two Departments, the Department of Early and Periodic Screening Diagnosis and Treatment/Outreach and the Department of Ancillary Services. The six programs managed under these Departments have a combined Federal-State budget of $15 million. The primary target population of these programs is 105,000 recipients under 21 years of age. Emergency dental services, post-surgical eyewear, and transportation services are provided to all eligible Medicaid recipients. Providers who participate in service delivery are dentists, physicians, optometrists, opticians, and a variety of clinics, school districts, hospital out-patient clinics, Rural Transit Authorities, Community Action Agencies, local Councils on Aging, volunteer transportation providers, and other State Agencies.

BUREAU OF HUMAN SERVICES

The Bureau of Human Services administers the Social Services Block Grant program, the primary source of Federal funding for the State's human service programs. The State is given the flexibility, within the broad Federal guidelines, to develop social service programs reflective of the State's priorities and concerns.

During Federal FY85-86, the Social Services Block Grant program consisted of 21 services with a Federal-State-local budget of $50,704,086. However, in March Federal funding was reduced $1.6 million. Approximately 60,000 clients will receive services through contracts with State Agencies and local private and other public providers. Some of the services provided are: protective services to abused and neglected children and adults, in-home services to the home-bound elderly, adoption and foster care for children without families who can care for them, child development for children of working parents, and special services for handicapped children and adults. All services are provided to low-income citizens in need except for protective services which are provided without regard of income. The Bureau of Human Services is organized into three Divisions, the Division of Program Development, the Division of Quality Assurance, and the Division of Program Monitoring.

Division of Program Development

This Division is responsible for program-specific planning, policy development, new initiatives, and the Bureau's input into decisions regarding funding allocations for services, the Social Services Block Grant Plan, and priority setting systems.

Division of Quality Assurance

Developing and implementing a quality assurance system is this Division's mission. In carrying out this responsibility the Division will develop service philosophies and standards, will develop methods for communicating standards and measuring compliance with standards, will analyze and interpret data gained from measurements, and will evaluate service effectiveness and compatibility with State objectives and priorities.

Division of Program Monitoring

This Division is responsible for monitoring human service contractors to determine degree of compliance with policy, for analyzing and interpreting data from monitoring efforts, for providing assistance in enhancing service provision, and for recommending negative sanctions against contractors when necessary.

BUREAU OF LONG TERM CARE

The Bureau of Long Term Care plans, administers, and directs the Medicaid institutional and non-institutional services. The Bureau provides planning, development, research, and demonstration projects to determine the efficiency of proposed policies and procedures. The

Bureau of Long Term Care consists of two Divisions, the Division of Home Health and Nursing Home Services and the Division of Community Long Term Care Services.

Division of Home Health and Nursing Home Services

The Division of Home Health and Nursing Home Services has the responsibility to develop a scope of services and to formulate instructions stipulated in provider manuals consistent with State and Federal laws and regulations. The Division promotes provider enrollment through coordination with the Contracts Division and the Department of Health and Environmental Control, Licenses and Certification Office. Staff functions are provided in the areas of education intervention, workshops as appropriate, and claim resolutions cleared consistent with policy. Program reviews are conducted on a continuous basis for compliance of changes and/or revisions to the Federal Regulations.

Qualitative services were rendered to approximately 13,000 eligible patients in skilled, intermediate, and intermediate/mentally retarded facilities during FY85-86. The Medicaid program sponsored reimbursement for nursing home care in 214 licensed and certified facilities with 14,907 beds. Home health providers were reimbursed during FY85-86 for 94,000 home visits.

A refined utilization review system was implemented on a phase-in basis in FY85-86 covering nursing home patients for alternative placement. Its purpose is to:

1. Strengthen the Nursing Home Utilization Review Committee activity.

2. Certify need for continuing care and utilization review by the nursing homes.

3. Intensify the Inspection of Care efforts to assure that standards are in compliance with Federal Regulations. These activities cover an improved assessment instrument utilized in the evaluation of the patients, increase the frequency of inspections to twice per calendar year, and develop procedures to take corrective action based on the inspection reports. The Department of Health and Environmental Control conducts the inspections under contract with the Health and Human Services Finance Commission.

Many hospitals participating in the Medicare (Title XVIII) program and the Medicaid (Title XIX) program, in addition to providing an in-patient hospital level of care, may also provide skilled nursing levels of care. A swing bed hospital must have fewer than 50 in-patient beds exclusive of newborn and intensive care type beds. The hospitals must be surveyed for compliance by the Department of Health and Environmental Control, Bureau of Health Licensing and Certification. The program was implemented for a period of June 1, 1986, through June 30, 1987, subject to review by the Health and Human Services Finance Commission for program utilization and appropriated funds.

Division of Community Long Term Care

The Division of Community Long Term Care is responsible for planning, directing, administering, and implementing the Commission's long term care non-institutional programs and the long term care mandatory pre-admission review program.

The purpose of the Community Long Term Care program is to provide a cost-effective alternative to premature or unnecessary nursing home placement under Medicaid and provide clients with a viable choice as to where they receive care: the home or in an institution. The program consists of ten area offices staffed by nurses, social workers, administrative, and clerical workers. The staff collects medical, psychosocial, and demographic data on Community Long Term Care clients and provides case management services to those qualified persons choosing to participate. They also prior authorize home- and community-based services which include personal care aid, respite care, medical day care, physical therapy, medical social work, speech therapy, occupational therapy, and home-delivered meals. These services are provided by for-profit and non-profit providers through Community Long Term Care contracts on a fee-for-service basis.

The claims are processed and paid by the Medicaid Management Information System. Data obtained through the Medicaid Management Information System is combined with that collected in the area offices to form the Community Long Term Care client control system, which provides a data base for long term care policy planning.

The program is funded by State and Federal dollars and is operated under a home- and community-based waiver program of the Medicaid program.

OFFICE OF OPERATIONS

The Office of Operations consists of three Bureaus, the Bureau of Planning, Research, and Budgets, the Bureau of Administrative Services, and the Bureau of Fiscal Affairs.

BUREAU OF PLANNING, RESEARCH, AND BUDGETS

Division of Planning

This Division is responsible for developing the Commission's strategic planning process and coordinating of the various plans for health and human services required of the Commission by Section 44-6-70 of Act 83. A State Plan must be prepared by the Commission for each program assigned to it. These include Medicaid and the Social Services Block Grant Plans. The Division's responsibilities also include two comprehensive plans, the State Health Plan (required by PL 93-641, as amended), and a State Human Services Plan. Both address broad population needs and problems, analyze resources of other State Agencies and the private sector, and include goals, objectives, and recommended actions for State Government and the private sector. Special studies are also a responsibility of this Division, as well as functions of the State Health Planning and Development Agency,

especially staff support for the Statewide Health Coordinating Council and its Committees.

Division of Research

Five functions are vested in the Division of Research. They are: (a) the evaluation and assessment of the Agency's effectiveness in achieving its stated goals and objectives, (b) the evaluation of agency programs, (c) data management services related to research for the Commission, (d) the provision of consultation, technical assistance, and data management and analysis services to other Agency units, and (e) the coordination and preparation of research grant funds necessary to accomplish Agency functions.

Division of Budgets

The Division of Budgets is responsible for the administration of the Commission's internal budgets and for the coordination and preparation of the Commission's annual budget request, throughout the State appropriation process. The Division is responsible for the various specific tasks that are inherent in those broad responsibilities. Specific functional tasks include certification of contract funding, coordination of appropriation transfers, and development of cost center budgets for operating expenses. The Director of the Division of Budgets is chairperson of the Commission's Budget Coordinating Council.

BUREAU OF ADMINISTRATIVE SERVICES

The Bureau of Administrative Services is responsible for providing the administrative support to the Commission in the areas of procurement, vehicle management, and inter-Agency and inter-office mail distribution. The Bureau is composed of the Division of Contracts, the Division of Appeals, and the Division of Support Services.

Division of Contracts

The Division of Contracts solicits, develops, and manages contracts, agreements, memorandums of understanding, or other documents which legally bind the Health and Human Services Finance Commission to other legal entities or to individuals. During FY85-86, the Budget and Control Board issued a two-year certificate authorizing the Agency to use State and Federal Social Services Block Grant Funds to:

1. Solicit and award contracts to qualified providers of direct services to eligible clients up to $750,000 per contract.

2. To solicit and award consultant contracts to qualified individuals, agencies, or firms, to complete studies and evaluations pertaining to the administration of the Block Grant Service Delivery System, and to make recommendations for improvements and efficiencies in the system. The Agency is certified to issue consultant contracts up to $150,000 per contract regardless of the source of funds.

Since Federal Regulations prohibit the Commission from denying a contract or participation in the Medicaid program to anyone who meets State and Federal requirements, all Title XIX contracts for the provision of services directly to clients were exempted from the State Procurement Code. Contracts funded with Medicaid dollars which include training, consultants, research of reimbursement methodology, accounting services, and others that are not providers of services directly to clients are not exempt from the State Procurement Code. The Procurement staff at General Services handles the solicitation and awarding of all contracts that exceed the certification amounts awarded to the Health and Human Services Finance Commission.

Department of Social Services Block Grant Contracts - The Commission continues to contract with the Department of Social Services for administrative support services. These services include eligibility and case management functions, data processing services for the maintenance and operation of the human services reporting system, and for monitoring for civil rights compliance. In addition to the administration services, the Health and Human Services Finance Commission also contracts with the Department of Social Services for the provision of 14 different services to eligible children and adults.

Other Block Grant Contracts - In addition to the Block Grant contracts with the Department of Social Services, the Health and Human Services Finance Commission also contracts with 50 agencies for child development services and with 54 Agencies for 13 additional services to eligible clients throughout the state.

Title XIX Contracts - The Commission continued to contract with the Department of Social Services for eligibility determination, the processing of Medicaid claims, maintenance of the Medicaid Management Information System, client transportation, early periodic screening, and preventive health services, civil rights compliance reviews, and certain accounting functions.

The Commission contracted with the Department of Health and Environmental Control for various planning functions, certification of need for nursing homes, inspection of care in nursing homes, community long term care service management and compliance reviews, home health services, physicians services, early periodic screening diagnosis and treatment outreach activities, the high risk channeling project, orthodontic services, hearing aids, immunizing agents, and laboratory service.

In addition to the contracts mentioned above, the Commission contracted with various Agencies, institutions, and individuals for a variety of Medicaid-covered services to eligible individuals.

During FY85-86, a Civil Rights Coordinator was employed to coordinate Commission compliance efforts with Civil Rights staff in the Department of Social Services and to assist in the investigations and processing of civil rights complaints against providers under contract. The Commission continued to contract with the Department of Social Services

for civil rights compliance reviews, but plans to assume more direct responsibility for this function during FY86-87.

Division of Appeals

The Division of Appeals is responsible for ensuring that administrative due process is accorded to all persons aggrieved by final Agency determinations by affording them an opportunity to be heard. Also, since January 1, 1986, the Agency has initiated several new programs which have doubled the number of appeals received monthly.

Division of Support Services

In January, 1985, the Division of Support Services within the Bureau was established. All purchasing functions were transferred from the Department of Social Services to the Commission. This Division provides the Commission with needed equipment, supplies, and services. This Division maintains a current inventory of all property assigned to the Commission. The fixed asset inventory system provides the needed information for inventories, audits, and other special reports.

BUREAU OF FISCAL AFFAIRS

The Bureau of Fiscal Affairs manages the general accounting functions of the Commission, including accounts payable and receivable, payroll, Federal funds management and expenditure reporting, and coordination of financial audits. This Bureau consists of three Divisions, the Division of Reporting and Receivables, the Division of Accounting and Control, and the Division of Third Party Liability.

Division of Reporting and Receivables

This Division performs all accounts receivable functions, develops the Commission's cost allocation plan, prepares periodic reports of Federal expenditures and designs, and maintains and implements the Commission's reporting system.

Division of Accounting and Control

Responsibility for all administrative accounts payable, Social Service Block Grant payables, payroll, account reconciliations, maintenance of the Federal Letter of Credit system, and the Commission's accounting system is vested in this Division.

Division of Third Party Liability

This Division is responsible for identifying other parties that are legally liable for payment of Medicaid services. For FY85-86 the Third Party Liability unit recovered $1,058,527. The Third Party Liability unit spearheads a yearly drive to recoup expenditures for Medicaid recipients who are also covered by Medicare. In FY85-86, that effort recouped $603,994.

OFFICE OF SYSTEMS AND CONTROL

The Office of Systems and Control is responsible for evaluating the

internal effectiveness in which the Commission is operating, investigating fraud and imposing sanctions, and coordinating automation of systems and flow of information.

BUREAU OF PROGRAM ASSESSMENT

The Bureau of Program Assessment is responsible for detection and investigation of Medicaid and Human Services fraud and abuse, investigation of complaints, and review of program policies and procedures that may permit aberrant practices.

Division of Health Program Integrity

The Surveillance and Utilization Review Subsystem in the postpayment review process permits the identification of providers whose patterns of practice vary significantly from their peers. The Division of Health Program Integrity conducts these reviews in accordance with Federal Regulations (42CFR Parts 455 and 456) and State standards. The Division has the responsibility to detect, identify, investigate, control, and prevent provider/recipient fraud and abuse of the Medicaid program.

Where indications of potential fraud exist, such cases are referred to the Office of the Attorney General. Administrative sanctions are imposed on providers where aberrant practices have occurred. When an investigation leads to a conviction, the sanctions imposed are, at the minimum, suspension from the program and recoupment of the overpayments. For cases where abuse has been identified, the sanctions recommended are recoupment of the overpayments and educational intervention.

The Disproportionate Stratified Random Sampling Technique is utilized in the conduct of postpayment reviews. Through application of a statistical formula an error rate is derived. This error rate is the basis for extrapolation of discrepancies throughout the provider's Medicaid history. Because staff identifies underpayments as well as overpayments, the final determination may be in favor of reimbursement of underpayments to or recoupment of overpayments from providers.

The provider receives a letter detailing the discrepancies found during the review and the amount involved. The appropriate program area in the Bureau of Health Services is provided a copy of this letter along with a memorandum requesting an educational intervention. The provider representative may handle the educational intervention by onsite visit, by written correspondence, by telephone, or any combination of these, depending on the seriousness of the discrepancies. A report of the method and content of the provider representative's contact is subsequently forwarded to the Division of Health Program Integrity. In this way it is assured that the provider is fully informed of the discrepancies and is given an opportunity to take corrective action.

BUREAU OF REIMBURSEMENT METHODOLOGY

The Bureau of Reimbursement Methodology is composed of three Divisions.

All are the vehicles used by the Commission for setting payment rates to providers. Most of the programs are Federally funded (72.7%). The remaining 27.3% is funded through State appropriations. We do, however, have one major health program (the Medically Indigent Assistance Fund) for in-patient hospital services that is funded by county governments and general hospitals. One of the three Divisions, the Division of Human Services Reimbursement, has yet to become active. It is still in the planning stage due to come on-line in October 1986. The two active Divisions, the Division of Long Term Care Reimbursement and the Division of Primary and Preventive Care Reimbursement are described.

Division of Long Term Care Reimbursements

This Division is responsible for the rate setting and the maintenance of the reimbursement methodologies associated with approximately 210 providers consisting of home health providers and nursing home providers.

Division of Primary and Preventive Care Reimbursements

This Division is composed of two Departments, each administering two separate, yet interrelated programs.

The Department of Medically Indigent Assistance Fund Reimbursement System is in charge of setting the rates and prices used to pay for the Medically Indigent Assistance Fund program as well as running the entire computer payment system for all medically indigent clients. The Medically Indigent Assistance Fund Computer System pays hospitals for in-patient hospital stays of medically indigent clients. There are 82 hospitals participating in this program, which was implemented January 7, 1986, with $7.5 million in half-year funding.

The Department of Prospective Payment Reimbursement Systems supervises and operates the hybrid diagnosis related group system for Medicaid hospital clients. This diagnostic related group system, the most complex in the nation, is part of the Medicaid program and hence is partly paid with State and Federal funds. The hybrid system is superimposed over the Medical Management Information system and drives all payments for all Medicaid patients for all hospital services. This system pays Medicaid contracted hospitals for Medicaid patients. There are 111 hospitals participating in the hybrid system.

BUREAU OF INFORMATION RESOURCES MANAGEMENT

The Bureau of Information Resources Management organizes, plans, directs, and approves the automated data processing efforts of the Commission, especially through the Information Resources Management Plan. In addition, the Bureau shall foster long-range planning to implement the State's information resources management strategy within the Agency.

Beginning October 1, 1986, the Bureau, which is divided into three Divisions, will be responsible for claims resolution for the Medicaid

Management Information System. A summary of each of the Divisions within the Bureau of Information Resources Management follows.

Division of Technical Support

The Division of Technical Support is responsible for providing the Agency with expertise in information resources equipment and software. This Division supports the other areas of the Commission by rendering technical advice to solve information management problems, procuring information technology to maintain and enhance existing information management systems, as well as supplying, when appropriate, software and training for mainframe and micro computers, and generating and assisting in generating reports from automated databases.

Division of Contracts Management

This Division is responsible for monitoring the Information Technology services provided to the Agency under contract. Contracts Management shall receive invoices for contracted services and approve their payment by acknowledging that these services have been received. Additionally, this Division will coordinate Information Technology contractor portions of internal and external monitoring of Commission performance.

Division of Medicaid Claims Resolution

This Division will review and process suspended Medicaid claims according to guidelines approved by the Bureau of Health Services. In addition, the Division of Medicaid Claims Resolution will often be responsible for ad hoc projects related to Medicaid claims processing, especially projects which result in adjustments to Medicaid providers.

APPENDIX B

SUMMARY OF LAW/STATUTORY AUTHORITY

To create the Health and Human Services Finance Commission, two bills were introduced at the 105th Session of the General Assembly. House Bill No. 2184 was introduced on January 12, 1983, and passed on May 19, 1983, with amendments. The Senate concurred with House amendments on May 30, 1983.

The authors of House Bill No. 2184 were: B. L. Hendricks, R. Schwartz, R. L. Altman, F. X. Archibald, D. L. Aydlette, D. Blackwell, T. M. Burris, M. D. Cleveland, M. J. Cooper, F. L. Day, P. Evatt, S. R. Foster, B. J. Gordon, D. O. Hawkins, I. C. Joe, H. H. Keyserling, J. Murray, J. J. Snow, J. H. Toal, M. Washington, D. Williams, and D. E. Winstead.

Senate Bill No. 132 was introduced on January 19, 1983. It passed the Senate on April 23, 1983. The authors of Senate Bill No. 132 were: H. E. McDonald, R. C. Dennis, H. J. Leatherman, I. E. Lourie, A. Sanders, and J. V. Smith.

Act No. 83, which created the Commission, was signed by Governor Richard W. Riley on June 7, 1983.

The law empowers the Commission to administer Title XIX of the Social Security Act (Medicaid), the Social Services Block Grant program, and to operate the Cooperative Health Statistics program.

The duties of the Commission are specifically stated in 44-6-40, South Carolina Code, 1976, as amended. The law, at 44-6-50, South Carolina Code, 1976, as amended, provides for the Commission to contract with health and human services agencies for eligibility determination and for the operation of a certified Medicaid Management Information Claims Processing System and for other operational components of the program which might be considered appropriate for the Commission.

In addition, this section of the law charges the Commission with the responsibility of monitoring and evaluating all contractual services and establishing a procedure whereby inquiries concerning the work of the Commission might be addressed expeditiously.

The law also creates the Health and Human Services Finance Commission Advisory Committee to assist and advise the Commission in its duties and functions.

Additionally, the law addresses priority areas of service, gives the Executive Director sole authority to employ and discharge Commission employees, and gives the Commission authority to promulgate regulations.

The statutory authority for various powers and duties of the Commission are as follows:

1. Section 44-6-10, South Carolina Code Ann. (Cum. Supp. 1984) creates the Health and Human Services Finance Commission and establishes the process for the selection of the members of the Commission.

2. Section 44-6-30, South Carolina Code Ann. (Cum. Supp. 1984) empowers the Commission to administer Title XIX of the Social Security Act (Medicaid) and to administer the Social Services Block Grant program, designates the Commission as the South Carolina Center for Health Statistics, and prohibits the Agency from engaging in the delivery of services.

3. Section 44-6-40, South Carolina Code Ann. (Cum. Supp. 1984) enumerates the duties imposed by statute upon the Commission.

4. Section 44-6-90, South Carolina Code Ann. (Cum. Supp. 1984) empowers the Commission to promulgate regulations to carry out its duties.

APPENDIX C

COMMISSION ADVISORY COMMITTEE

This Committee is established by State law to assist and advise the Commission in its duties and functions. The State law creating the Health and Human Services Finance Commission also created this Advisory Committee. The Committee will provide advice on health and social policies and plans being proposed for consideration by the Commission and other issues the Commission may feel appropriate. Members of the Committee will be available to serve on task forces of the Commission as needed.

Responsibility

In fulfilling its role as advisor to the Commission, the Committee will perform at least the following functions:

1. Assist the Commission in developing State policy and to review State plans for conformity with established State policy.

2. Review and recommend approval of the Social Services Block Grant Plan, but not specific provider allocations.

3. Review and comment on changes proposed in the Medicaid State Plan.

4. Review and comment on Statewide Health and Human Service needs.

5. Review and comment on implementation strategies for health and human service programs.

6. Review and comment on proposed human services program regulations and legislation.

7. Review and comment on proposed criteria for evaluation of human service programs.

Structure

To facilitate the work of the Finance Commission Advisory Committee, a broad-based group has been appointed with a wide range of expertise and community concerns. The appointed membership is supplemented by the Chief Executive Officer of the relevant State Agencies. This broad-based Advisory Committee encompasses the areas of expertise and concerns to carry out its functions of advising the Finance Commission on overall policy and review of State plans. In order for the effectiveness of this broad-based Committee to not be diluted the Advisory Committee functions as a single unit. However, the bylaws provide for the appointment of study committees should in-depth study be required.

Membership

The members are set forth in State law and the Governor will appoint

the Chairman and the thirteen members at large. In addition, State law specified fifteen ex officio members without voting rights.

Meeting Dates

Meetings are held on the first Tuesday of each month.

APPENDIX D

MEDICAL CARE ADVISORY COMMITTEE

The Medical Care Advisory Committee is established by Federal law 42CFR431.12, which establishes the responsibilities of the Council.

Responsibility

A Medicaid State Plan must provide for a Medical Care Advisory Committee meeting the requirements of the CFR to advise the Medicaid Agency Director about health and medical care services. The Committee must have opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the Agency program. The Agency must provide the Committee with:

1. Staff assistance from the Agency and independent technical assistance as needed to enable it to make effective recommendations.

2. Financial arrangements, if necessary, to make possible the participation of recipient members.

The Committee will review and comment on all Commission plans and laws, regulations, and policies which directly affect the Medicaid program. Members of the Committee will serve on task forces of the Commission, as needed.

Structure

The Chairman appoints subcommittees, as necessary. Bylaws allow for a Budget Subcommittee and a Policy and Operations Subcommittee. Both Subcommittees are currently inactive.

Membership

The Commission will appoint the members on a rotating and continuous basis, conforming to Federal requirements, who will represent the providers and consumers of its services. The Committee must include:

1. Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care.

2. Member of consumers' groups, including Medicaid recipients,

and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others.

3. The director of the public welfare department or the public health department, whichever does not head the Medicaid Agency.

Meeting Date

The Medical Care Advisory Committee is currently meeting on the second Thursday of each month.

APPENDIX E

STATEWIDE HEALTH COORDINATING COUNCIL

The Statewide Health Coordinating Council was established by the National Health Planning and Resources Development Act (Section 1524 of Public Law 93-641, as amended by Public Law 96-79) and Code of Laws of South Carolina, Sections 44-5-20, 44-5-50 et. seq.

Responsibility

Responsibilities of the Statewide Health Coordinating Council are as follows:

1. Prepare and review at least triennially, and advise as necessary, the State Health Plan.

2. Establish a uniform format for Health Systems Plans.

3. Review and coordinate at least triennially the Health Systems Plans of the Health Systems Agencies in the State.

4. Review at least annually the Annual Implementation Plan of each Health System Agency in the State.

5. Review annually the budgets of the Health Systems Agencies in the State as well as their grant applications.

6. Advise the State Health Planning and Development Agency generally on the performance of its functions.

7. Implement those parts of the State Health Plan not pertaining to State Government, and not ascribed to another entity, for which the Statewide Health Coordinating Council accepts responsibility.

8. Review annually and recommend approval or disapproval of any State Plan and any application submitted to the Secretary as a condition to the receipt of certain funds (Proposed Uses of Federal Funds review).

Structure

The Chairman is appointed by the Governor with the advice and consent

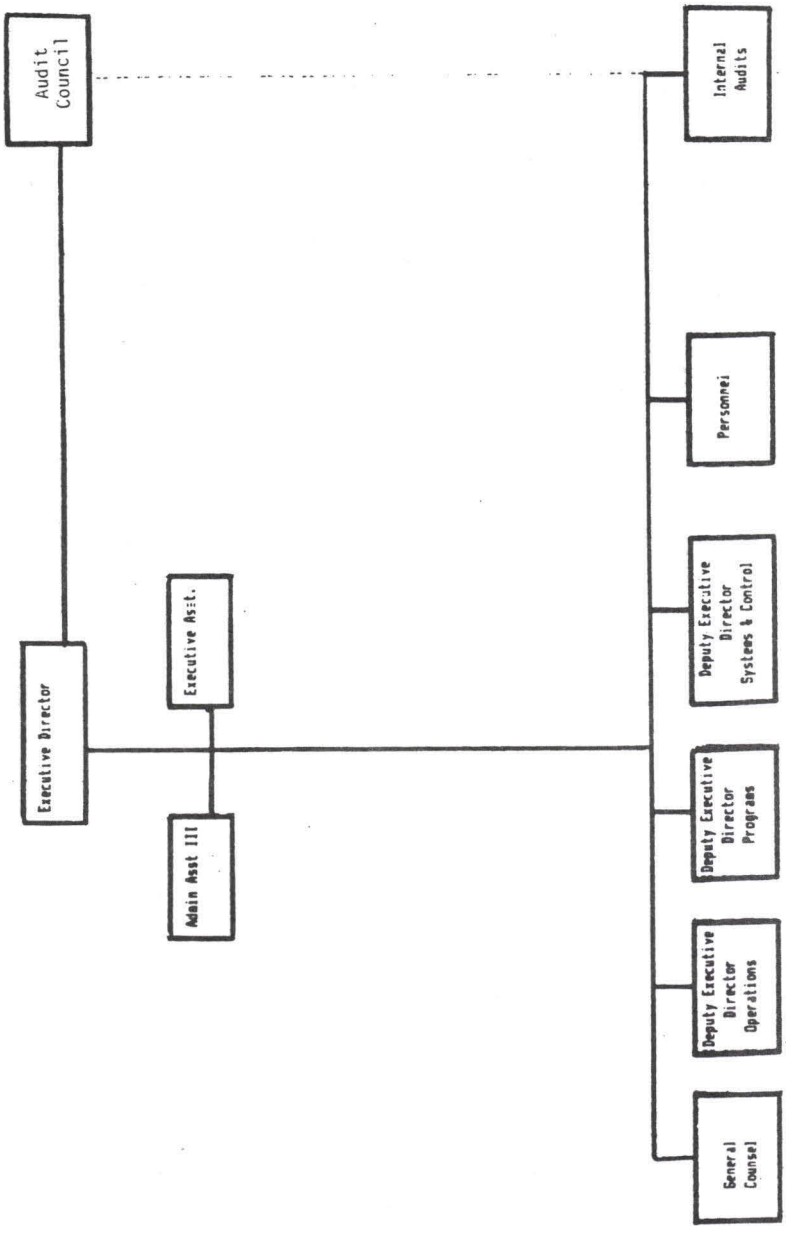
of the South Carolina State Senate. If the Governor does not select the Chairman, the Council selects the Chairman from among its members. The rules and regulations for the Council organization and operation are provided by the Council's bylaws. The Statewide Health Coordinating Council also provides input and assistance to the Commission through two standing Committees.

Membership

Membership consists of 29 members, 28 of whom are appointed by the Governor and one by the Chief Director of the Veteran's Administration. Of the 28 members appointed by the Governor, 17 (nine consumers and eight providers) are appointed nominations submitted by the Health Systems Agencies. The Governor has 11 discretionary appointments (six consumers and five providers). All members serve three-year terms. The Veteran's Administration appointee is a non-voting, ex officio member.

Meeting Date

Meeting dates are set by the Council and depend on work requirements. A minimum of one meeting per quarter is required. Edwin R. Mohrmann is Chairman.



APPENDIX F

MANAGEMENT ORGANIZATION CHART

APPENDIX G

Health and Human Services Finance Commission

Analysis of Expenditures: FY1985-86 (1)

	Adjusted Appropriation		Expenditures	
	Total (2)	State	Total	State
Operating				
Personal Services	5,574,825	2,180,285	5,301,007	2,011,189
Fringe Benefits	1,180,372	449,015	911,484	343,889
Other Operating	3,350,787	1,576,944	2,949,877	1,353,227
Total Operating	10,105,984	4,206,244	9,162,368	3,708,305
Medical Support Contracts				
Regular Medicaid	5,657,618	1,215,240	3,852,508	1,007,510
CLTC	3,702,405	764,594	2,755,624	581,048
Total Med. Sppt. Cntrs.	9,360,023	1,979,834	6,608,132	1,588,558
DSS Medical Management	13,396,523		9,278,010	
Hlth Sys Agencies Plan & Health Planning- DHEC	300,180	190,180	290,695	190,180
MEDICAID				
Regular Medicaid	293,903,186	73,541,537	284,015,894	73,327,360
Medically Needy	17,158,434	4,753,718	16,669,847	4,730,379
CLTC	9,527,137	2,400,390	4,084,085	1,111,321
Other Agencies	95,065,452	123,477	66,983,902	122,793
FY85-86 Reduction	1,833,015	1,833,015		
TOTAL MEDICAID	417,487,224	82,652,137	371,753,728	79,291,853
TOTAL SSBG	48,321,596	3,207,597	37,327,404	3,190,681
Medically Indigent Assistance Fund	7,580,000		7,240,484	
TOTAL AGENCY	506,551,530	92,235,992	441,660,821	87,969,577

NOTES: (1) Source of data is FY85-86 Comptroller General report CSA424CM.
(2) "Other Funds" provided as matching funds by other agencies and providers are included under appropriation balances but not under expenditures; only cash transactions are captured on Comptroller General reports.